While UK dentistry events are generally well supported by UK clinicians, comparatively few are able to attend gatherings in the USA. In February, I was fortunate to be present at the Chicago Mid Winter meeting, probably one of the largest international dentistry gatherings after the IDS in Cologne. The weeklong congress began with a ‘summit’ led by Gordon Christensen focusing on US dental laboratories, sponsored by a group, which for the last four years has been promoting US dental technology and US trained dental technicians.

While this ‘summit’ covered topics such as Continuous Professional Development (CPD) for dental technicians, patient disclosure documents for all custom-made dental appliances and the key topic of entry-level education and training. However, the underlying reason behind the summit is the growing concern, which is likely to become increasingly relevant to the UK dental laboratory dental market within the near future, regarding the outsourcing of the manufacture of dental prostheses.

A danger to livelihoods?
A conservative estimate suggests that up to one fifth of custom-made, relatively straightforward dental appliances are now imported into the USA. A natural anxiety is growing across the domestic industry associations, including the ADA (the American Dental Association) that the time will come when there will be no skilled technicians left in the country to create the higher-quality, more complex and high value added prostheses demanded by the cosmetic customer/patient. There is apprehension that the transfer of all prosthetic manufacture to the Far East laboratories will damage the more discriminating patient’s ‘dental experience’, with severe consequences for dentists’ livelihoods in the US.

Securing a future
The relationship between US dentists and their laboratories is as competitive and commercial as it is in the UK, and they were not attending a technicians’ summit for purely altruistic reasons. Fully aware of the challenge to their own prosperity posed by the threat to the US laboratories, they have joined forces with the technicians to lobby state and national governments in an effort to secure their own futures as well as that of the appliance manufacturers. While some might suggest this is protectionism, I would suggest they have every justification in protecting themselves and their own futures!

On this side of the Atlantic, the Health Select Committee review has taken place. It was encouraging to observe that independent presentations to the committee from both dental and dental technology organisations put forward similar views on this subject, and perhaps an appearance of solidarity across the industry on other matters, such as the new NHS contract, in an effort to secure their own futures as well as that of the appliance manufacturers. While some might suggest this is protectionism, I would suggest they have every justification in protecting themselves and their own futures!

It’s well known that where the US leads, the UK tends to follow. Is it time for a ‘lab summit’ between UK dentists and technicians, to harmonise approaches to government and attempt to safeguard the future for the different branches of the industry over here?

joined-up thinking
Is a united front for dentistry between UK dentists and technicians to safeguard the future, the best approach to government? Richard Daniels investigates

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Endo treatment softening the blow

Offering care and reassurance to patients frightened of pain, should really start before they even get into the chair, so carrying out treatment isn’t made difficult, says Dr Michael Sultan

T
o most of our patients, root canal treatment is synonymous with pain. If a patient’s finding treatment uncomfortable is to be believed, so it’s important that they’re made to feel at ease from the start.

A patient’s first point of contact is usually the receptionist, who should feel confident when putting the patient at ease, by greeting them in an empathic, reassuring, informative and helpful way. A medical background is far less important than excellent people skills at this point, and makes the difference between having a defensive and anxious patient and a fully informed patient who knows what to expect, how long treatment will take and how much it will cost.

Recording pain history
After the initial gentle greeting, the first step is to take a full history of the patient’s experience with pain, as well as a social and medical history. The pain history quickly allows us to assess whether the pain is of dental or non-dental origin, and if tooth related whether it may be primarily endodontic or periodontal. It also makes the patient feel they are talking to someone who is genuinely listening with real empathy.

Any special tests required should be explained to the patient from the start, and maintaining a reassuring dialogue during the process will maximise results. Only once the diagnosis has been ascertained and treatment plan explained and agreed can treatment actually begin.

Sedation as an option
If the patient is particularly anxious, it’s a good time to discuss sedation so that they can be treated in a more comfortable state. Many are only nervous about the actual injection – doing this slowly and calmly is a real skill. In our experience, the Wand has proved the most successful method in giving a local anaesthetic.

Although the rubber dam has been used to great advantage in dentistry for over 100 years, it isn’t a common sight in a lot of practices. It effectively ‘takes the tooth out of the mouth’ for treatment. Not only does it save time and maintain a clean, dry field, it can also stop potential legal problems later. Dam placement can take as little as 10 seconds and once the clamp has been placed, my DSA will pass me the dam already on the frame ready for placement.

The best way to improve a patient’s acceptance of the rubber dam is for clinicians to use it frequently and proficiently. If the patient is claustrophobic, the dam can be cut back to provide a breathing hole. Many of the patients appreciate not having water and fluids building up at the back of their throat and genuinely feel more comfortable.

Props are used as routine. This stops the patients suffering from aching joints and jaws and reduces TMJ problems later. At the end of the procedure, many cannot remember if their mouths are open or not as their muscles have relaxed so much.

Given that endodontic treatment is lengthy, noisy and potentially quite stressful for a patient, it is good to offer a pleasant distraction such as a personal music player or the latest video glasses for listening to music or watching DVDs.

Communicate clearly
On completion of any treatment/procedure, it is a good idea to tell the patient what to expect in terms of pain, bruising and swelling. It really helps to take an analgesic at the end of the procedure before the injections wear off and if pain is expected, alternating regular three-hourly doses of paracetamol (500mg) and ibuprofen (400mg) give optimal pain relief.

Endodontic treatment may involve a certain amount of discomfort, but if time is taken to explain to the patient exactly what you are going to do and how it will feel afterwards, they will be prepared and able to tolerate a greater degree of discomfort than if they are taken by surprise.

A sympathetic follow-up phone call the day after treatment is reassuring and allows the patient to voice any anxieties associated with their recovery. Patients really respond to and appreciate clear and concise communication at every stage of the process.

Endo treatment – softening the blow

Dr Michael Sultan

BDS MSc DPO

is a specialist in endodontics and the clinical director of EndoCare. Michael qualified at Bristol University in 1986 and worked as a general dental practitioner for five years before commencing specialist studies at Guy’s Hospital in London. He completed his MSc in endodontics in 1995 and worked as an in-house endodontist in various practices before setting up in Harley Street, London in 2000. He was admitted onto the specialist register in endodontics in 1999 and has lectured extensively to postgraduate dental groups, as well as lecturing at university courses at Eastman CDU, University of London. He has been involved with numerous dental groups, has been chairman of the Alpha Omega dental fraternity and in 2008, became clinical director of EndoCare, a group of specialist practices. Dr Michael Sultan can be contacted for advice regarding patients or any issues raised by the articles on michael@endopro.co.uk.

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